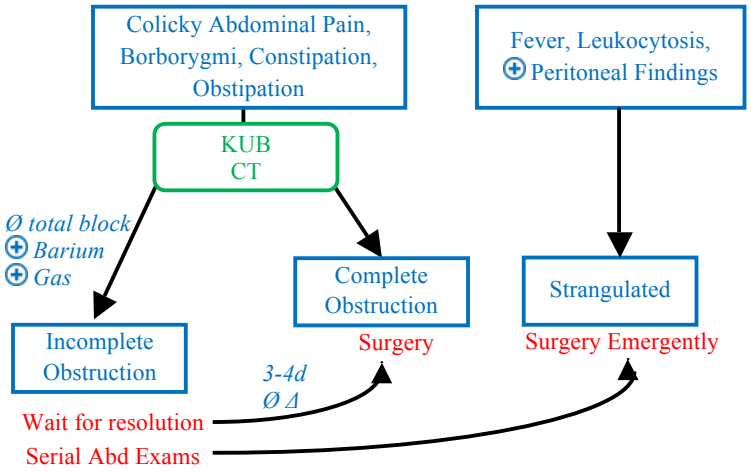
Introduction

The main point in dealing with the bowel is to decide if there's a need to operate or if we can can watch and wait. If someone is ever **peritoneal** (rebound tenderness, involuntary guarding) they go to **surgery**. Beyond that, it's knowing when to go to surgery and when to attempt conservative measures that defines questions of the small bowel.

Small Bowel Obstruction

SBO is caused by either **adhesions** (most common with previous abdominal surgeries) or **hernias** (most common cause without previous surgery). There will be **colicky abdominal pain** with progressive distention of the abdomen. Early on, there will be ⊕ **gas/stool** and a condition called **borborygmi** where there are **high-pitched, rapid, crescendo** bowel sounds. Late, the distal intestines decompress while the proximal bowel swells. At this point, there are **Ø bowel sounds** and **Ø gas or stool**. Confirm what's seen on an **upright KUB** (1st test, dilated loops of bowl with air-fluid levels) with either a **small bowel series** (ingested barium and serial x-rays) or a **CT-Scan**. If they are peritoneal or there's a complete bowel obstruction, they go to **Ex-Lap**. If they have an incomplete obstruction do **serial exams** and attempt **conservative measures** (fluids, potassium and NG tube decompression).



Hernias

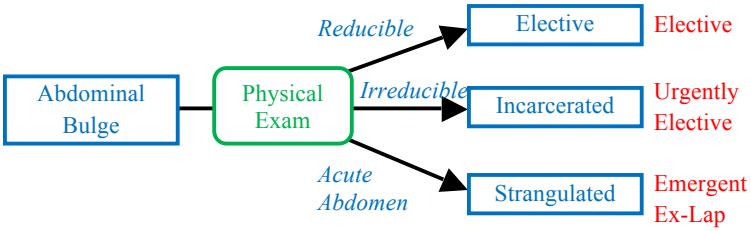
Hernias are just a **wall defect** that intestines can move through. **Direct** hernias are groin hernias of adults that pass directly through the **transversalis fascia** and are the "*adult hernia*". **Indirect** hernias are groin hernias which pass through the **inguinal** ring, an embryonic defect, so are the "*baby hernia*". **Femoral** hernias are groin hernias pass **under** the **inguinal ligament** and are the "*lady hernia*." Finally, the most common is a **ventral** hernia, caused by an incomplete closure after surgery (i.e. **iatrogenic**) "*surgery hernia*". Hernias aren't a big deal so long as the hernia is **reducible**. If it becomes **irreducible** (that is, it becomes **incarcerated**) it can present with obstruction. Reducible is considered elective, incarcerated urgent. If the incarcerated hernia turns **strangulated**, with obvious peritoneal signs and an affected hernia, it becomes a surgical emergency requiring **emergent Ex-Lap**.

Question is: When do Hernias go to OR?

1. Emergent = Black/Blue, Acute Abdomen, Sepsis
2. Urgent = Acutely irreducible or +SBO without Emergent
3. Elective = reducible hernia and Ø SBO and Ø Acute Abd

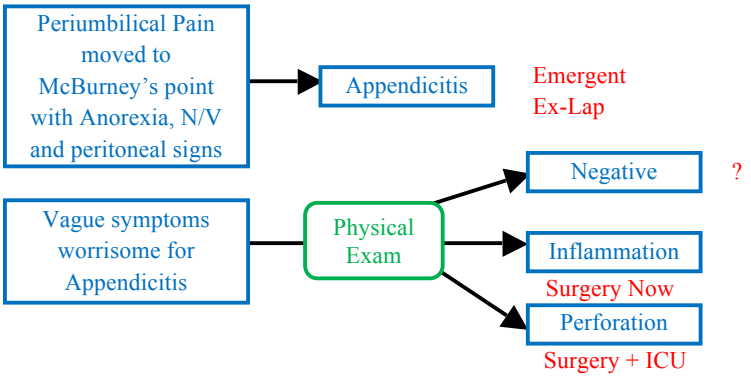
Question is: What type is it?

♀ = Femoral Hernia, under ligament *Lady hernia*
♂ adult = direct, through transversalis *Adult hernia*
♂ baby = indirect, through the inguinal ring *Baby Hernia*
Surgery = Ventral, through abdominal wall *Surgery hernia*



Appendicitis (technically large bowel, I know)

A patient who presents with a classic history doesn't need diagnostic tests. Go straight to treatment (surgery). A patient that presents with **anorexia**, then vague **periumbilical pain** that resolves but comes back at **McBurney's Point** (RLQ) with **focal peritoneal** findings is appendicitis. If unsure, get a **CT scan** while preparing the OR. For the test, if the diagnosis is obvious **go straight to surgery**.



Carcinoid

Let's briefly mention it. Carcinoid produces **serotonin**. Intestinal serotonin is degraded by the liver. With **mets to the liver**, serotonin goes to the **R heart** causing fibrosis, flushing, wheezing, and diarrhea. The lungs degrade serotonin sparing the L heart, releasing **5-HIAA** to be excreted into the urine; it is used as a screening tool for the cancer. It must be staged and resected.